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I. Welcome and Introductions	Cindi Jones Director, Virginia Department of Medical Assistance Services (DMAS)	1:00 pm
II. Virginia Updates	Sarah Broughton, MSW, CCC Program Analyst, DMAS & Aubrey G. Lucy, Project Manager, MAXIMUS	1:05 pm
III. Committee Member Focus Session 1: ***CCC Evaluation Update***	Gerald Craver, PhD Senior Research Analyst Policy and Research Division, DMAS	1:20 pm
IV. Committee Member Focus Session 1: ***CCC Quality Update***	Jason Rachel, PhD, Supervisor CCC Operations, DMAS & Fuwei Guo, MPH, Integrated Care Quality Analyst, DMAS	1:50 pm
V. Committee Member Focus Session 3: ***Managed Long-Term Supports and Services (MLTSS) Update***	Tammy Driscoll, Senior Programs Advisor to the Deputy of Complex Care and Services, DMAS; Karen E. Kimsey, Deputy Director of Complex Care & Services, DMAS; Terry A. Smith, Director, Division of Long-Term Care, DMAS; Tammy Whitlock, Director, Division of Integrated Care and Behavioral Health Services, DMAS	2:10 pm

VIRGINIA UPDATE

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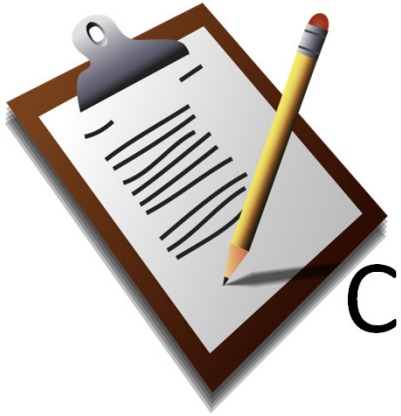
Tammy Whitlock, Director: Division of Integrated Care & Behavioral Health Services

Sarah Broughton, MSW: CCC Program Analyst

Virginia Update for CCC Advisory Committee

August 18, 2015



DMAS Supportive & Contract Monitoring Activities

- Observations, HRAs, POCs, ICTs, etc.
- Care Coordinator Training
  - Care Coordinator survey to assess topics desired to augment ongoing MMP training
  - Topics also based on stakeholder feedback

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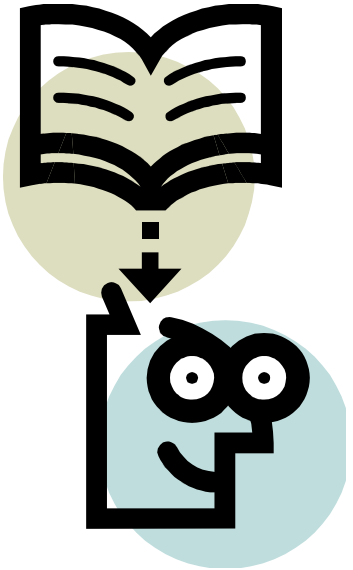
DMAS Care Coordinator Training



- Training topics included:
  - Waiver services
  - Provider relations
  - Person-centered care planning
  - Contract Requirements & More
  - In-person with each MMP
  - 2 Rounds of training conducted thus far (April and June 2015), more training Fall 2015

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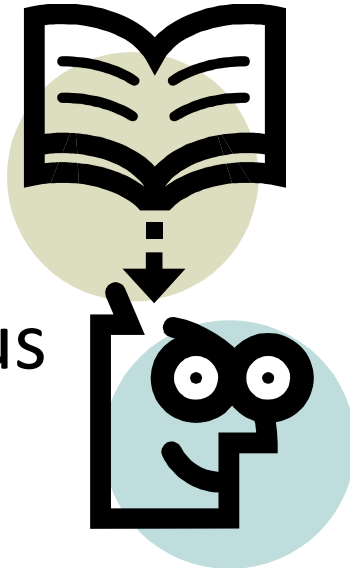
DMAS Care Coordinator Training



- Currently holding twice monthly calls for the Care Coordinators for Q&A on various topics
  - Calls average 135-170 participants
  - Care Coordinators can ask questions in advance or live on call
  - Start by sharing educational resources
  - Address questions raised in last training
  - Option for polling questions
  - Positive response from Care Coordinators!

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Aubrey Lucy, Project Director

MAXIMUS

August 18th, 2015

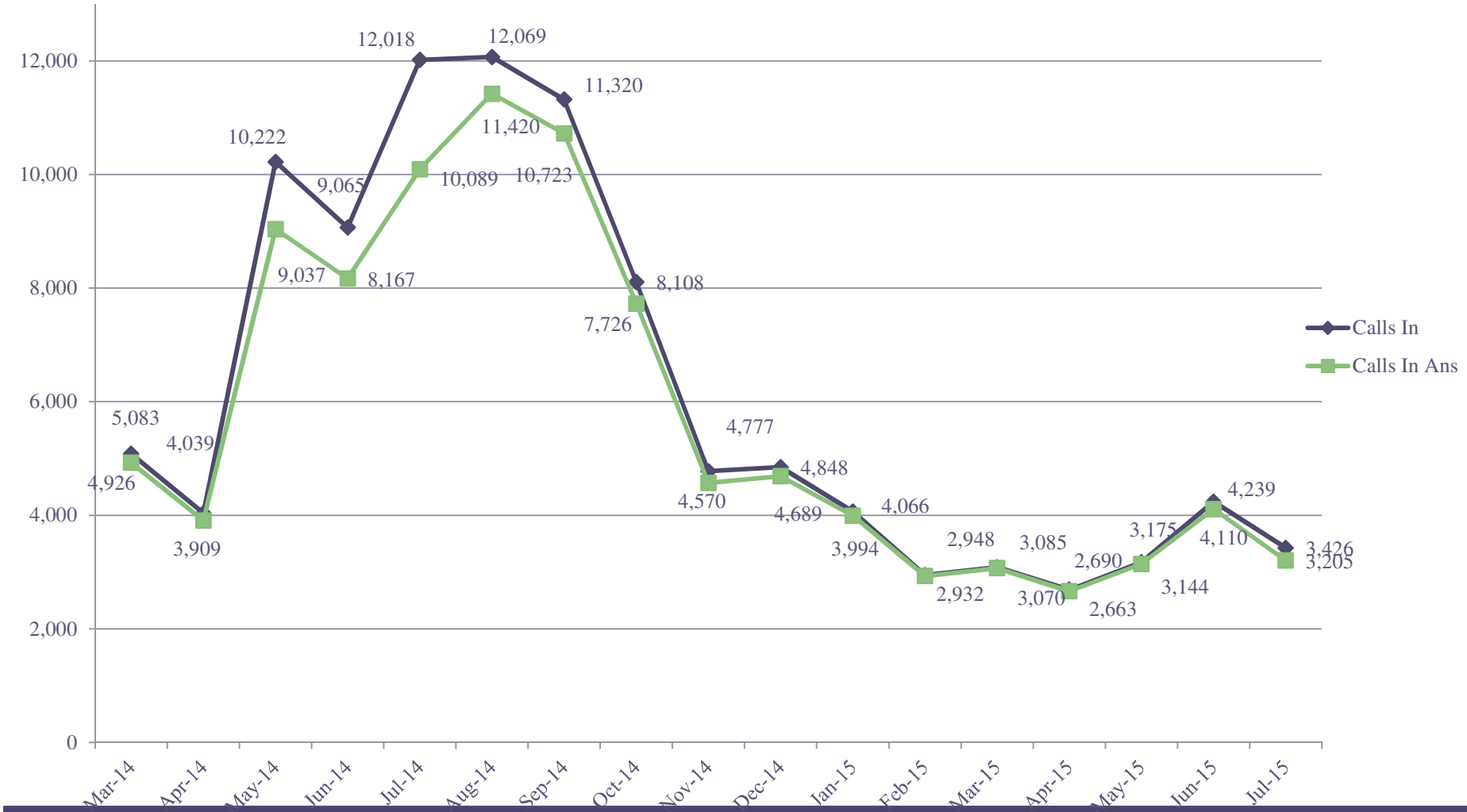
CCC – Call Center Operations Review

- Call Volumes and Trends
- Beneficiary Escalations Log
- MAXIMUS' Monthly Best Practices Conference Call with States and CMS

CCC – Call Center Operations Review

Calls Inbound/Calls Inbound Answered

3/1/2014 - 7/31/2015 (by Month)



CCC – Call Center Operations Review

- Beneficiary Escalations Log
  - Complaints Easily and Efficiently Handled
  - Log is sent two times per day

DMAS - TRACKING ISSUES LOG																
Call Date	Beneficiary Name	Medicaid ID	HICN	Contact Phone #	Current MMP Per VAMISS	Opt In Date	Opt Out Date	Issue/Action Requested Red Font denotes DMAS callback req. by Bene.	URGENT	Date Sent To DMAS	AM/ PM Log	DMAS Resolution	Date Sent Back to Maximus	Closed	Type of Call	"Other" Call Type Detail

CCC – Call Center Operations Review

- MAXIMUS Operates 9 of the 11 Duals Demonstrations
- Monthly Best Practices Call with MAXIMUS, the 9 States, and CMS
- Purpose is to share best practices among the Projects, States, and CMS

Commonwealth Coordinated Care Program Evaluation Update

Stakeholder Advisory Committee
August 18, 2015

Gerald A. Craver, PhD

Overview

- **Review of CY 2014 – 2015 Care Coordination Observations**
- **Care Coordination Case Studies**
- **New Evaluation Document - *The Beneficiary Experience* (September 2015)**
- **Next Steps**
- **Questions, Comments, or Concerns**

Care Coordination Observations

- In evaluation, observations are essential because they happen in the "field" where services are delivered, allowing evaluators to learn more about program activities and processes
- Purpose of CCC observations is to observe delivery of services in real time to develop a more holistic understanding of the program
- Data collection consists of note taking, while observing care coordinators interacting with enrollees, families, and providers supplemented with interviews and document reviews

Observation Overview

- Since June 2014, the evaluation team has conducted 33 observations (79.2 hours) representing 73 encounters around the Central, Charlottesville, Roanoke, and Tidewater demonstration regions
- Data collection guided by certain questions:
  - What type of activity is occurring?
  - How does the enrollee receive needed assistance?
  - Is care for the enrollee being coordinated and if so, how and how well?

Observation Summary (*Tentative*)

- **Activities:**
  - HRAs, ICTs, follow-ups, medical rounds, care planning, and MMP/enrollee meetings
- **Assistance:**
  - Assessing needs, advocating, coaching, communicating, educating, building relationships, providing supplies, and connecting to social and health care supports
- **Care Coordination:**
  - Building relationships, communicating, collaborating, resourcing, and delivering services

Case Study #1 – ICT Meeting

An MMP care coordinator (CC) and social worker conducted ICT on an enrollee with serious mental illness/liver mass at request of CSB due to concerns about losing residence at assisted living facility. ICT at local adult day support facility, and MMP, Magellan, support facility staff and enrollee participated. During meeting, staff assessed enrollee's cognitive abilities and enrollee asked MMP/Magellan staff to continue visiting her. MMP/Magellan staff indicated that enrollee had improved some since last meeting and concluded that residing in assisted living facility was beneficial. They agreed to work with support network to help enrollee adjust to facility and to schedule CT scan to examine her liver.

Case Study #2 – Clinical Assessment

During a clinical assessment of an enrollee with several chronic conditions, medical staff determined that she had undiagnosed chronic kidney disease (stage 3) and lower extremity problems due to poor circulation. Staff reviewed medications, performed cardiac evaluation, and referred enrollee to podiatrist and exercise staff for further care. Staff communicated findings to enrollee's primary care physician (PCP) and MMP CC and scheduled quarterly visits with enrollee to begin CKD and lower circulatory treatment. Staff will continue to share treatment results with PCP and CC.

Case Study #3 – Initial Assessment

A CC conducted assessment of two newly assigned elderly enrollees (husband/wife) with various chronic conditions. During the encounter, CC determined they had limited English language abilities and were hungry (husband motioned to mouth saying "please"). After conversing with nursing facility (NF) staff, CC determined that NF lacked appropriate translation services. CC offered to arrange services and asked NF staff to convene care plan meeting with husband as soon as possible to discuss needs. NF staff expressed strong desire to collaborate to ensure delivery of suitable care to enrollees.

Case Study #4 – ICT Meeting

A CC conducted ICT with enrollee, service facilitator (SF), and family member. Prior to ICT, CC contacted PCP for follow up issues. CC reviewed care plan, medications (reduced from 15 to 8), and PERS with enrollee/family member. CC also offered to contact DME provider for replacement walker and to work with SF to resolve attendant pay issue. After ICT, CC reported that enrollee appeared to exhibit symptoms of an undiagnosed chronic disease, which she planned to share with PCP. During separate interview, SF reported that CC is good about following up with enrollees and communicating with providers (she goes "above and beyond the duties of her job".)

The Beneficiary Experience (Sept. 2015)

- Short document (1 -3 pages) that portrays CCC Program from perspective of a specific enrollee, care coordinator, and/or other LTSS/BH provider(s) (may include one or more photographs)
- First *Beneficiary Experience* focuses on a Humana LTSS enrollee, care coordinator, and home health nurse
  - Beneficiary enrolled in CCC since April 2014
  - Receiving services through Humana's AAA pilot

CCC Enrollee Describing Relationship with Care Coordinator

…[she] really stays in touch with me to see if I need anything and when I do…she goes out of her way to do it…I don't even think of her as a coordinator, I just think of her as a friend…without her, who would I have to help me…hmm…nobody…I wouldn't have anybody except for the home care agency…I think that's a good idea, having a coordinator…I needed a Rollator…she went out of her way to make sure [I got it]…she tells me about things…like Silver Sneakers…she helps me when I do my [pharmacy] orders…she answers my questions…when I had to find a dermatologist, she quickly mailed me the list of people in the network…she stays on top of things, I don't know what else to say…

Next Steps

- Continue interviewing BH/LTSS enrollees and providers and observing MMP care coordination activities across demonstration regions in both institutional and community settings
- Partnering with Hampton/Newport News CSB and Richmond Behavioral Health Authority and District 19 CSB to conduct focus groups with BH enrollees/family members in August/September
- George Mason submits findings from surveys of CCC enrollees/disenrollees by September 30th

Questions, Comments, or Concerns

- ***THANK YOU!***
- For additional information on the CCC Evaluation, please contact:
  - **Gerald Craver**
    gerald.craver@dmas.virginia.gov
    804-786-1754
  - Or visit the **CCC Evaluation website**
    http://www.dmas.virginia.gov/Content_pgs/ccc-eval.aspx

Commonwealth Coordinated Care Quality Update

Stakeholder Advisory Committee
August 18, 2015

Jason Rachel, PhD: Supervisor CCC Operations

Fuwei Guo, MPH: Integrated Care Quality Analyst

Highlights

- CCC Quality Oversight Structure and Summary of Progress

- Updates on Quality Projects:
  - 2015 External Quality Review Audit
  - 2015 CCC Member Survey
  - Upcoming Utilization Dashboard

Two Components of Quality Oversight

Quality Assurances and Compliance	Quality Improvement
Ongoing Contract Management Team (CMT) Contract Monitoring	2015 QM Plan and 2014 QM Evaluation
Additional DMAS Contract Monitoring	MMP Quality Improvement Projects (QIP/CCIP)
CMS and DMAS Audits	VA Specific Withhold Methodology

EQRO Activities

- External Quality Review Organization (EQRO) – Health Services Advisory Group (HSAG)
  - Largest EQRO in the nation
  - Serves as the CMS QIO

- EQRO Activities Highlights:
  - 2015 MMP Operation System Review Audit
    - Pre-onsite Activities
    - Onsite Activities
    - Post-onsite Activities

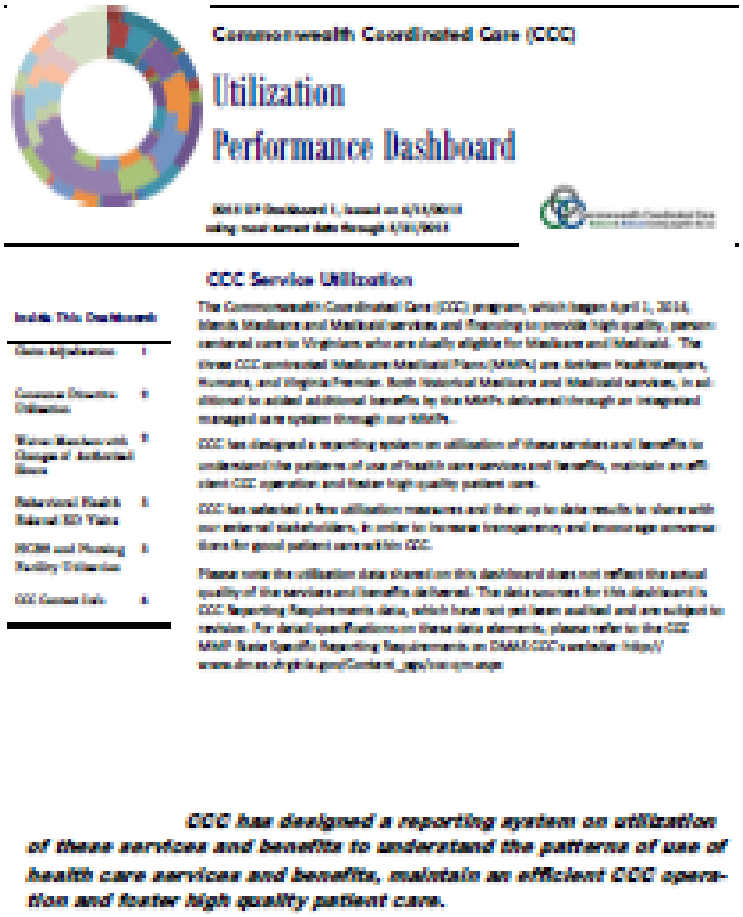
2015 Merged Survey

- Annual Member Satisfaction Survey and Quality of Life Survey requirements – 2015 Merged Survey
- Survey Project Team comprised of DMAS and MMP representatives
- Administration Timeline: 09/2015 to 12/2015
- Eligible Population: Active member with 6+months of continuous CCC enrollment
- Sample Size: 1200 Per MMP
- Survey Method: CAHPS like - mail followed up with phone calls
- Survey Questionnaire: Short 21-question survey

Utilization Dashboard

Data and Summary for:

- Timely LTSS Clean Claim Adjudication
- Waiver Members using Consumer Direction
- Waiver Members who experienced an Increase or Decreased in Authorized Hours



Commonwealth Coordinated Care (CCC)

Utilization Performance Dashboard

CCC Service Utilization

CCC has designed a reporting system on utilization of these services and benefits to understand the patterns of use of health care services and benefits, maintain an efficient CCC operation and foster high quality patient care.

THANK YOU

For additional information on CCC Quality Monitoring, please:

- Visit the **CCC Quality Monitoring webpage** http://www.dmas.virginia.gov/Content_pgs/ccc-qm.aspx
- Or Contact our CCC team CCC@dmas.virginia.gov

Proposed Initiatives for Medicaid Managed Long-Term Services and Supports (MLTSS)

CCC Advisory Committee

August 18, 2015

MLTSS Presentation Agenda

- Managed Long Term Services and Supports
  - *Definition*
  - *General Assembly Mandates*
  - *DMAS MLTSS Vision and Goals*
- Current DMAS Program Models
- Future MLTSS Initiatives
- Stakeholder Involvement
- Next Steps
- Questions and Discussion

What is MLTSS?
Managed Long Term Services and Supports

MLTSS

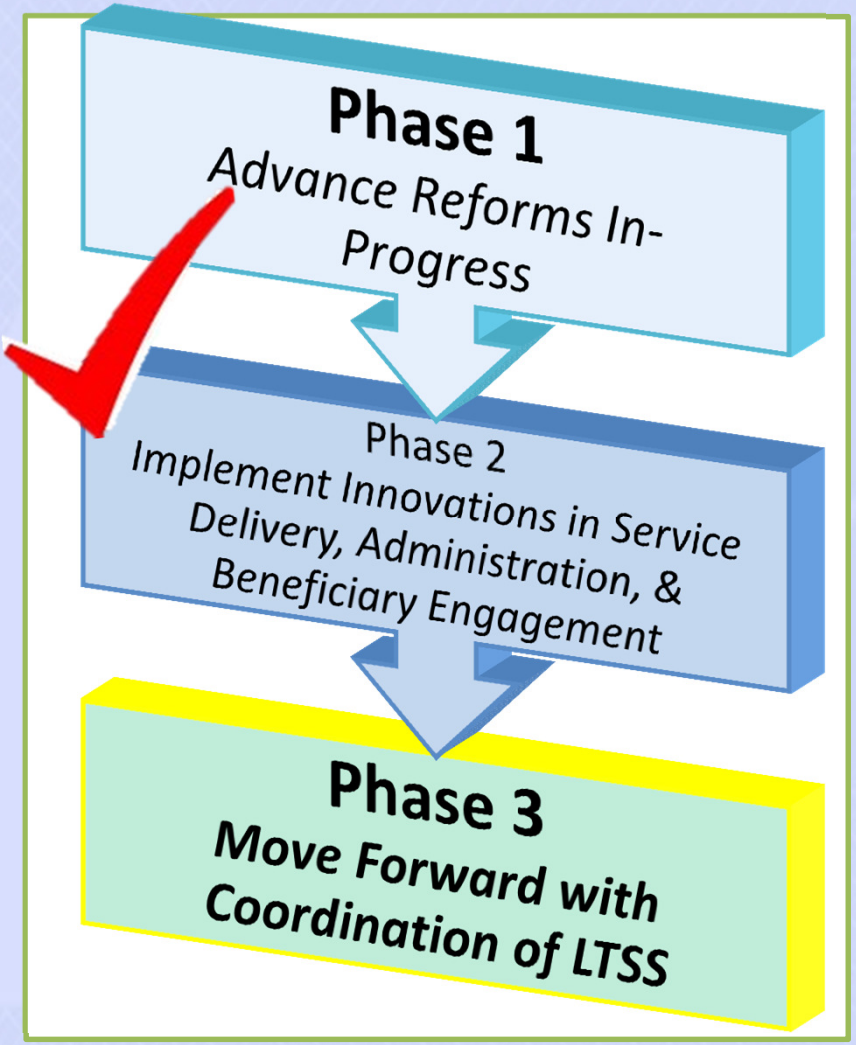
Managed Long-Term Services and Supports (MLTSS) refers to the delivery of long term services and supports, including both home and community based services (HCBS) and institutional-based services, through capitated Medicaid managed care programs

Legislative Mandates/Reform Initiatives

GENERAL ASSEMBLY MANDATES

Beginning in 2011 and continuing through 2015, the Virginia General Assembly has directed DMAS to continue efforts to transition fee-for-service (FFS) populations into managed care to take advantage of the value that managed care provides to enrollees and to the Commonwealth

MEDICAID REFORM INITIATIVES



MLTSS VISION AND GOALS

- *Coordinated system of care that focuses on improving access, quality, and efficiency*
  - Improves quality of care and quality of life
  - Promotes innovation, especially to enhance community-based infrastructure and improved community based service capacity
  - Reduces service gaps with focused attention on individuals with complex needs, such as individuals with intellectual disabilities, multiple chronic conditions, and/or serious mental illness
  - Provides access to high-quality, timely and appropriate care and provides flexibility to serve individuals before they have higher needs

MLTSS VISION AND GOALS (continued)

- Operates under a fully-integrated, patient centered program design
- Provides coordination between physical health, behavioral health, and LTSS, as well as collaboration with relevant social and community providers
- Includes value based purchasing (example – models that incent and reward providers for high-quality care)
- Better manages and reduces expenditures and provides for budget predictability (full-risk, capitated model)

Current DMAS Service Models

Serving Over A Million Individuals

Medallion 3.0 and FAMIS

Includes children, pregnant women, adults (caretakers), foster care children, and some aged, blind, and disabled (ABD); excludes LTSS

Commonwealth Coordinated Care (CCC)

Includes full-benefit adult duals (age 21 and older); includes CCC eligible nursing facility and EDCD Waiver individuals

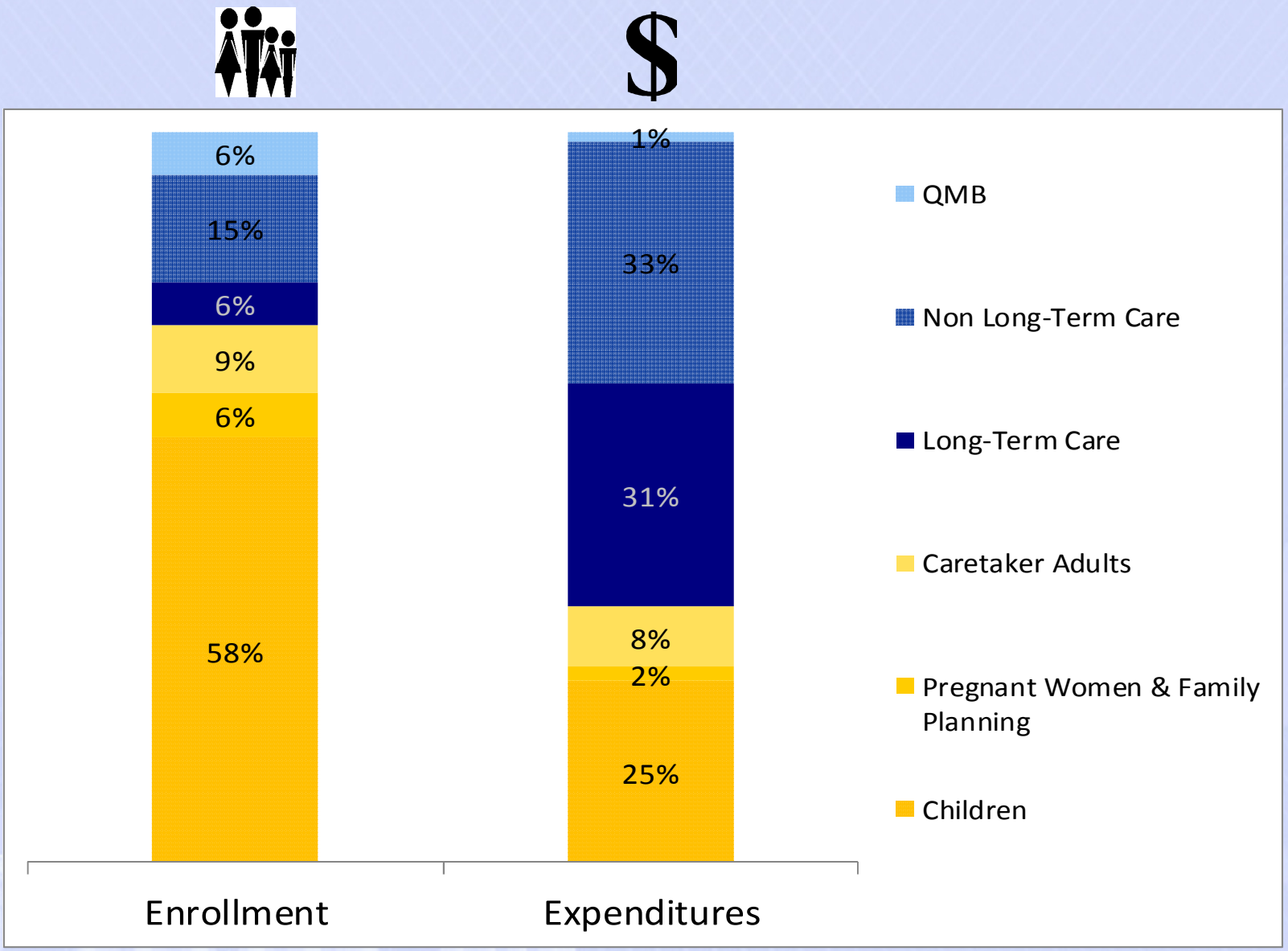
Program of All-Inclusive Care for the Elderly (PACE)

Includes adults age 55 and older who meet nursing facility criteria; community alternative to nursing facility care

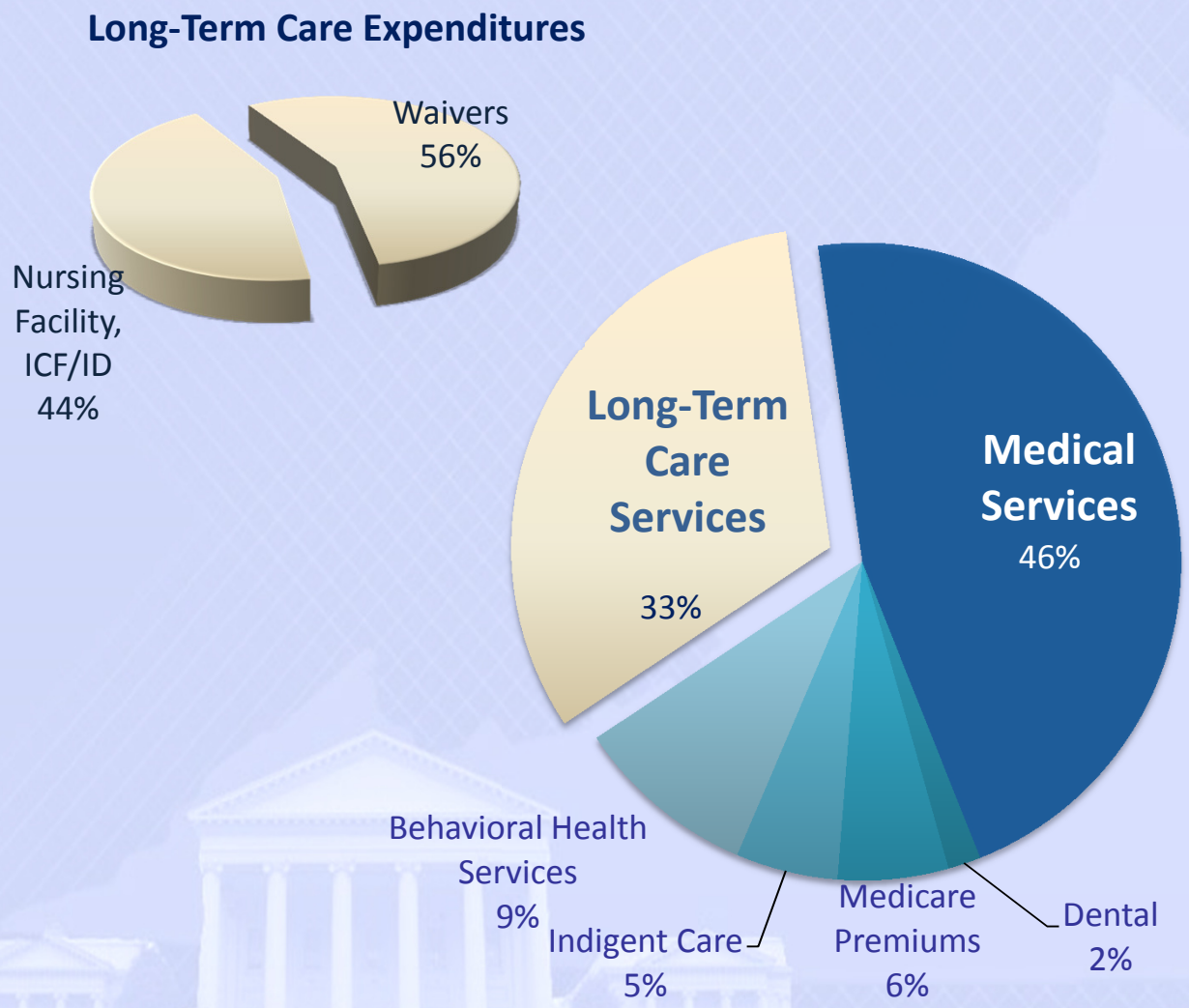
Fee For Service (FFS)

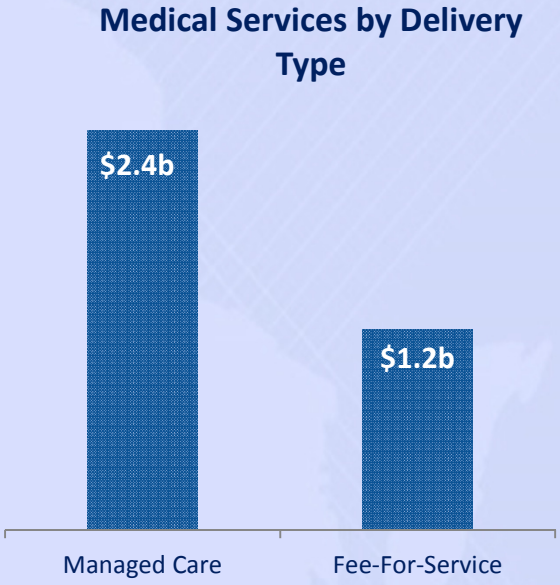
- Dual eligibles who opt-out of/or who are not eligible for of CCC,
- Individuals that receive LTSS who are not in CCC/HAP (Medallion 3.0),
- Individuals with other insurance coverage, presumptive eligibles, and individuals awaiting managed care enrollment,
- Limited Coverage Groups (GAP, Plan First, QMBs/SLMBs, HIPP)

Medicaid Enrollment v. Spending

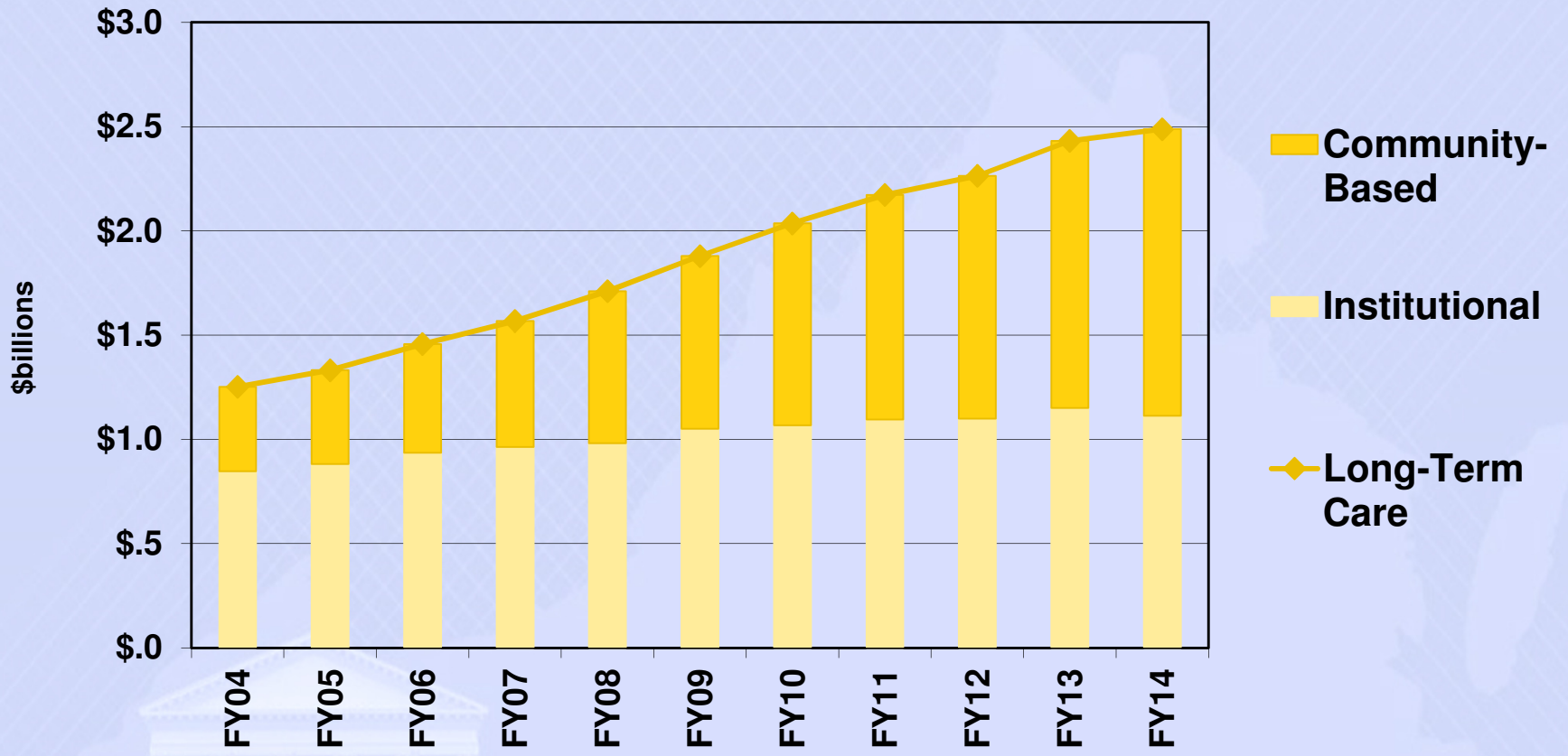


Composition of Virginia Medicaid Expenditures SFY 2014





Rebalancing of Long-Term Institutional and Community-Based Services



Notes:

Average annual growth total Long Term Care services – 7%

Average annual growth Institutional services– 3%

Average annual growth Community-Based services– 13%

Proportion of Long Term Care services paid through Community-Based care has increase from 32% in FY04 to 55% in FY14

Virginia Medicaid HCBS Waivers – Enrollment and Wait List Information

Slot/Wait List Summary	Enrollment As of June 2015	Waiting List
EDCD	30,880	N/A
ID	10,038	8,058 (4,937 urgent, 3,121 non-urgent)
DD	909	1,013
Tech	294	N/A
Day Support	276	8,058 (4,937 urgent, 3,121 non-urgent)
Alzheimer's	55	N/A

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The Plan

To transition 107,000 individuals to managed care model(s) that are designed to provide them with enhanced opportunities to improve their lives

Populations to Transition from FFS to MLTSS

Duals Eligible for CCC and Who are Not Enrolled
(Approximately 37K)

Duals Excluded From the CCC Demo
(Approximately 50K)

Medicaid Only Individuals Receiving LTSS
(Approximately 20K)
Includes HAP

MLTSS *Proposed* Strategy

MLTSS for CCC Eligible Individuals *Who Opt-out of CCC*

- Enroll individuals that opt out of CCC with one of the existing CCC plans for their Medicaid coverage;
- Would operate concurrently with the CCC demonstration (same populations/services);
- Earliest start date would be July 1, 2016.

MLTSS for Duals and LTSS Individuals *Who Are Not CCC Eligible*

- Competitively procure MLTSS plans (RFP);
- Populations would be phased in regionally;
- Earliest start date would be mid-year 2017.

Future DMAS Service Models

MANAGED LONG TERM SERVICES AND SUPPORTS

Commonwealth Coordinated Care (CCC)

Fee For Service (FFS)

Program of All-Inclusive Care for the Elderly (PACE)

Medallion 3.0 (M3)

Moving Forward

- Over the next 2 years, the FFS population will decrease
- Most individuals will be served through one of the managed care models
- DMAS has established a MLTSS project implementation team
- MLTSS may be implemented in multiple phases (2016-2017)

Stakeholder Involvement

- Stakeholder involvement is crucial
  - Request for Public Comment
  - Meetings with Health Plans
  - Town Halls
  - Meetings with Stakeholder Groups (including Advisory Committee)

Questions and Discussion

References

MLTSS updates will be posted as available on the DMAS website at:
http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

Implementing Medicaid Reform in Virginia (Report to the General Assembly of Virginia, January 2014)
http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD62014/$file/HD6.pdf

CMS Technical Assistance Tools for MLTSS:
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html